

FILED MAR 13 1945
Registration District No. 43

Primary Registration District No. 2007

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Bartlett
(b) City or town Caplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lucy Lee Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hours
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM R. GARRISON

3. (b) If veteran, name war none 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Eva Garrison 6. (c) Age of husband or wife if alive, years _____

7. Birth date of deceased April 24, 1882
(Month) (Day) (Year)

8. AGE: Years 53 Months 8 Days 20 If less than one day hr. _____ min. _____

9. Birthplace Bloomfield, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Wiley Garrison

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Malissa Taylor

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Eva Garrison

(b) Address Malden, Mo.

17. (a) Burial (b) Date thereof Jan. 22, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker Cemetery
Bloomfield, Mo.

18. (a) Signature of funeral director George S. Mosher

(b) Address Advantage 1220

19. (a) 2-26-45 (b) Gene Turner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
(c) City or town Malden
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20
year 1945 hour 11 minute A.M.

21. I hereby certify that I attended the deceased from Jan 20, 1945 to Jan 20, 1945
that I last saw h. _____ alive on Jan 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation
Cardiac Failure
Due to 3-degree uterine
burns (Entire body)

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. A. Markel M.D. (M. D. or other) _____

Address Caplar Bluff, Mo. Date signed 2-22-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No.

District File Number 345-3

Date Filed 3/8/45

OCT 16 1945

MAR 20 1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Gloyd S. Morgan
working under my personal supervision.

Registered Apprentice No.

Signed Gloyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, Va

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 43 Primary Registration District No. 2007 Registrar's No. 50

1. PLACE OF DEATH:
 (a) County Butler
 (b) City or town Poplar Bluff
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Wm R. Garrison
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex M **5. Color or race** W **6. (a) Single, widowed, married, divorced** M
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased April 28 1898
 (Month) (Day) (Year)

8. AGE: Years 53 Months 8 Days _____ If less than one day, hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)
Subroad employee
10. Usual occupation _____
Stollon Beer R.R.
11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ **(b) Date thereof** _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ **(b)** _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 28
 year 1945 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw h. _____ ally on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____
 Due to _____
 Due to _____
 Other conditions _____ (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Major findings: _____
 Of operations _____
Of autopsy _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence Jan 20 1945
 (c) Where did injury occur? Home (City or town) Madison, Mo (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature W. D. Markel (Specify type of place) Kerosene Explosion
 (e) Means of injury _____
Address Poplar Bluff, Mo **Date signed** _____
 (M.D. or other)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI DEPARTMENT OF HEALTH

S-5653 1945

OCT 16 1945